

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN3003	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  11/29/2011
NAME OF PROVIDER OR SUPPLIER  LAUGHLIN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 E MCKEE ST GREENEVILLE, TN 37743		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies  During the Life Safety portion of the survey conducted on November 28-29, 2011, no licensure deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 002	Laughlin Healthcare Center acknowledges during the Life Safety portion of the annual survey conducted on November 28-29, 2011, no licensure deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*B. B. A.*

TITLE

*Nursing Home Administrator*

(X6) DATE

*12.09.11*

STATE FORM

6899

HZK621

If continuation sheet 1 of 1